Labor Health and Human Services, Education, and Related Agencies
Witness Disclosure Form

Clause 2(g) of rule XI of the Rules of the House of Representatives requires non-governmental witnesses to disclose to the Committee the following information. A non-governmental witness is any witness appearing on behalf of himself/herself or on behalf of an organization <u>other</u> than a federal agency, or a state, local or tribal government.

Your Name, Business Address, and Telephone Number:

George A. Macones, M.D.

[redacted]

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.

ACOG

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2008?

Yes (No)

3. If your response to question #2 is "Yes", please list the amount and source (by agency and program) of each grant or contract, and indicate whether the recipient of such grant or contract was you or the organization(s) you are representing.

N/A

Signature: [redacted]

Date: 3-28-12

Dr. George A. Macones, M.D., M.S.C.E., assumed his role as Chair of Obstetrics and Gynecology at Washington University in St. Louis on September 1, 2005. He also serves as the Director of the Division of Maternal-Fetal Medicine and Ultrasound in the Department of Obstetrics and Gynecology. Prior to this, he was on the faculty at the University of Pennsylvania for 11 years, spending his last 6 years as Director of Maternal-Fetal Medicine and Director of Obstetrics. Dr. Macones is an internationally recognized expert in perinatal clinical research, and has held RO1 grants from NICHD, NHLBI, and NCI. He has over 100 peer-reviewed publications related to clinical research in obstetrics. His research interests include general obstetrical issues (labor induction, VBAC) and the prediction and prevention of preterm birth. He has served on numerous national committees, including the FDA's Advisory Committee on Reproductive Drugs and on several study sections for NIH. He has worked closely with ACOG, and currently serves as Chair for the Committee on Obstetrical Practice Bulletins. He also serves on the Board of Directors for the Society for Maternal-Fetal Medicine, is Associate Editor of the *American Journal of Obstetrics and Gynecology*, and is Co-Chair for the ACOG Task Force for PROLOG Obstetrics.

Dr. Macones received his M.D. from Jefferson Medical College in 1988. He completed his residency in Obstetrics and Gynecology from Pennsylvania Hospital in 1992, and went on to complete a fellowship in Maternal-Fetal Medicine at Thomas Jefferson University Hospital in 1994. He also received his M.S.C.E. from the University of Pennsylvania in 1996.

Testimony Submitted by the
American Congress of Obstetricians and Gynecologists (ACOG)

US House Committee on Appropriations
Subcommittee on Labor, Health and Human Services and Education
Department of Health and Human Services (HHS)

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The American Congress of Obstetricians and Gynecologists, representing 57,000 physicians and partners in women's health care, is pleased to offer this statement to the House Committee on Appropriations, Subcommittee on Labor, Health and Human Services, and Education. We thank Chairman Rehberg, and the entire Subcommittee for the opportunity to provide comments on some of the most important programs to women's health. Today, the US lags behind other nations in healthy births, yet remains high in birth costs. ACOG's Making Obstetrics and Maternity Safer (MOMS) Initiative seeks to improve maternal and infant outcomes through investment in all aspects of the cycle of research, including comprehensive data collection and surveillance, biomedical research, and translation of research into evidence-based practice and programs delivered to women and babies, and we urge you to make this a top priority in FY13.

Data Collection and Surveillance at the Centers for Disease Control and Prevention (CDC)

In order to conduct robust research, uniform, accurate and comprehensive data and surveillance are critical. The National Center for Health Statistics is the nation's principal health statistics agency and collects state data from records like birth certificates that give us raw, vital statistics. The birth certificate is the key to gathering vital information about both mother and baby during pregnancy and labor and delivery. The 2003 US-standard birth certificate collects a wealth of knowledge in this area, yet 25% of states are still not using it. States without these resources are likely underreporting maternal and infant deaths and complications from childbirth and causes of these deaths remains unknown. Use must be expanded to all 50 states, ensuring that uniform, accurate data is collected

nationwide. **ACOG supports the President's FY13 Budget Request of $16.45 million to modernize the National Vitals Statistics System, which would help states update their birth and death records systems.**

The Pregnancy Risk Assessment Monitoring System (PRAMS) at CDC extends beyond vital statistics and surveys new mothers on their experiences and attitudes during pregnancy, with questions on a range of topics, including what their insurance covered to whether they had stressful experiences during pregnancy, when they initiated prenatal care, and what kinds of questions their doctor covered during prenatal care visits. By identifying trends and patterns in maternal health, researchers better understand indicators of preterm birth. This data allows CDC and state health departments to identify behaviors and environmental and health conditions that may lead to preterm births. Only 40 states use the PRAMS surveillance system today.

Biomedical Research at the National Institutes of Health (NIH)

Biomedical research is critically important to understanding the causes of prematurity and developing effective prevention and treatment methods. Prematurity rates have increased almost 35% since 1981, and cost the nation $26 billion annually, $51,600 for every infant born prematurely. Direct health care costs to employers for a premature baby average $41,610, 15 times higher than the $2,830 for a healthy, full-term delivery. A breakthrough study conducted by the Eunice Kennedy Shriver National Institute for Child Health and Human Development (NICHD) last year showed a significant reduction in preterm delivery among women with short cervixes who are administered vaginal progesterone. The results were especially positive in reducing births pre-28 weeks. The results of this study are expected to save the health care system $500 million a year. Additional research can help drive down our prematurity rates further, saving dollars and lives. **Sustaining the**

investments at NIH is vital to achieving this goal, and therefore ACOG supports a minimum of $32 billion for NIH in FY13.

Adequate levels of research require a robust research workforce. The average investigator is in his/her forties before receiving their first NIH grant, a huge dis-incentive for students considering bio-medical research as a career. Complicating matters, there is a gap between the number of women's reproductive health researchers being trained and the need for such research. The NICHD-coordinated Women's Reproductive Health Research (WRHR) Career Development program seeks to increase the number of ob-gyns conducting scientific research in women's health in order to address this gap. To date 170 WRHR Scholars have received faculty positions, and 7 new and competing WRHR sites were added in 2010.

Public Health Programs at the Health Resources and Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC):

Projects at HRSA and CDC are integral to translating research findings into evidence-based practice changes in communities. Where NIH conducts research to identify causes of preterm birth, CDC and HRSA fund programs that provide resources to mothers to help prevent preterm birth, and help identify factors contributing to preterm birth and poor maternal outcomes. The Maternal Child Health Block Grant at HRSA is the only federal program that exclusively focuses on improving the health of mothers and children. State and territorial health agencies and their partners use MCH Block Grant funds to reduce infant mortality, deliver services to children and youth with special health care needs, support comprehensive prenatal and postnatal care, screen newborns for genetic and hereditary health conditions, deliver childhood immunizations, and prevent childhood injuries.

These early health care services help keep women and children healthy, eliminating the need for later costly care. Every $1 spent on preconception care for women with diabetes can reduce health costs by up to $5.19 by preventing costly complications in both mothers and babies. Every $1 spent on smoking cessation counseling for pregnant women saves $3 in neonatal intensive care costs. The MCH Block Grant has seen an almost $30 million decrease in funding in the past 5 years alone. **ACOG urges you not to cut the MCH Block Grant any further and for FY13 we request $645 million for the Block Grant to maintain its current level of services.**

Family planning is essential to helping ensure healthy pregnancies and reducing the risk of preterm birth. The Title X Family Planning Program provides services to more than five million low-income men and women at more than 4,500 service delivery sites. Every $1 spent on family planning results in a $4 savings to Medicaid. Services provided at Title X clinics accounted for $3.4 billion in health care savings in 2008 alone. **ACOG supports $327 million for Title X in FY13 to sustain its level of services.**

The Healthy Start Program through HRSA promotes community-based programs that help reduce infant mortality and racial disparities in perinatal outcomes. These programs are encouraged to use the Fetal and Infant Mortality Review (FIMR) which brings together ob-gyn experts and local health departments to help specifically address local issues contributing to infant mortality. Today, more than 220 local programs in 42 states find FIMR a powerful tool to help reduce infant mortality, including understanding issues related to preterm delivery. For over 20 years, ACOG have partnered with the Maternal and Child Health Bureau to sponsor the designated resource center for FIMR Programs, the National FIMR Program. **ACOG supports $.5 million for HRSA to increase the number of Healthy Start programs that use FIMR.**

The Safe Motherhood Initiative at CDC works with state health departments to collect information on pregnancy-related deaths, track preterm births, and improve maternal outcomes. The Initiative also promotes preconception care, a key to reducing the risk of preterm birth. **For FY13, we recommend a sustained funding level of at least $44 million for the Safe Motherhood Program, and the inclusion of a $2 million preterm birth sub-line to ensure continued support for preterm birth research, as authorized by the PREEMIE Act.**

Regional quality improvement initiatives encourage use of evidence-based quality improvement projects in hospitals and medical practices to reduce the rate of preterm birth. Under the Ohio Perinatal Quality Collaborative, started in 2007 with funding from CDC, 21 OB teams in 25 hospitals have decreased scheduled deliveries between 36 and 39 weeks gestation, in accordance with ACOG guidelines, significantly reducing pre-term births.

Finally, ACOG is proud to partner with the Department of Health and Human Services and the March of Dimes on Strong Start, a multi-faceted perinatal health campaign to reduce preterm births. Strong Start contains two strategies. The first is a public-private partnership reduce elective deliveries prior to 39 weeks through a public awareness campaign and quality improvement efforts. The second is a funding opportunity to test innovative prenatal care approaches to reduce preterm births for women covered by Medicaid and at risk for preterm birth. Strong Start has the potential to make a huge difference in reducing the rate of pre-term birth. We urge the Committee to continue investing in programs like Strong Start.

Again, we would like to thank the Committee for its consideration of funding for programs to improve women's health, and we urge you to consider our MOMS Initiative in FY13.